Medicare Hospital Manual

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 747 **Date: DECEMBER 1999**

REFER TO CHANGE REQUEST 1032

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-3 - 4-4 (2pp.)	4-3 - 4-4 (2pp.)
442 - 442.8	4-423 - 4-426.4 (8pp.)	4-423 - 4-426.3 (7pp.)
452 - 455 (Cont.)	4-499 - 4-500.2a (5pp.)	4-499 - 4-500.2 (4pp.)
460 - 460 (Cont.)	4-501 - 4-504 (4pp.)	4-501 - 4-504 (4pp.)
460 (Cont.) - 460 (Cont.)	4-552.5 - 4-552.6 (2pp.)	4-552.5 - 4-552.6 (2pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: April 1, 2000
IMPLEMENTATION DATE: April 1, 2000

Section 442, HCFA Common Procedure Coding System (HCPCS), has been modified to address HCPCS codes not used by Medicare, and how your intermediary will handle the reporting of these codes in their systems.

Section 442.6, Reporting Outpatient Services Using HCFA Common Procedure Coding System (HCPCS), includes the following revisions in preparation of a hospital outpatient prospective payment system:

- Requires line item dates of service for every line where a HCPCS code is reported on all outpatient bills; and

- Redefines the reporting of service units for outpatient services where HCPCS reporting is required. A unit is redefined as the number of times the service or procedure reported was performed.

Section 442.8, Non-Reportable HCPCS Codes, is being **deleted** because of the expanded HCFA-1450 claim.

Section 452, Billing for Hospital Outpatient Partial Hospitalization Services, includes a requirement for line item date of service reporting, and revises the instructions for reporting service units when billing for partial hospitalization services.

Section 460, Completion of Form HCFA-1450 for Inpatient and/or Outpatient Billing, has been updated for expanded HCFA-1450 claim and revises the instructions for reporting hospital outpatient services in FL 45 (Service Date) and FL 46 (Units of Service).

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Section

Uniform Billing

Electronic Media Claims Data

HCFA-1450

Billing in Situations Where Medicare Is Secondary Payer

Billing in Medicare Secondary Payer Situations

442. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

HCPCS is based upon the American Medical Association's (AMA) Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). It includes three levels of codes and modifiers. HCFA monitors the system to ensure uniformity. Level I contains only the AMA's CPT-4 codes. This level consists of all numeric codes. The second level contains the codes for physician and nonphysician services which are not included in CPT-4, e.g., ambulance, DME, orthotics and prosthetics. These are alpha-numeric codes maintained jointly by HCFA, the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA). Level III (local assignment) contains the codes for services needed by individual contractors or State agencies to process Medicare and Medicaid claims. They are used for services which are not contained in either other level. The local codes are also alpha-numeric, but are restricted to the series beginning with W, X, Y, and Z.

There are certain HCPCS codes that are not used by Medicare. If you report them on a claim with other services which are covered, your intermediary will deny the line item as non-covered. They will attach the appropriate ANSI code for the denial to their RA and to the crossover record sent to any subsequent payer. Do not RTP the claim unless you have failed to also include parallel codes. If so, they will notify you to submit the correct codes to Medicare in order to obtain payment. Usually, the codes not used by Medicare are Level I codes and Medicare makes payment using Level II codes instead.

Level I (CPT-4) codes/modifiers can be purchased in hardcopy form or a tape/cartridge from:

American Medical Association
P.O. Box 7046
Dover, DE 19903-7046

Telephone 1-800-621-8335

Level II (non-CPT-4) codes/modifiers can be purchased in hardcopy form from:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Telephone (202) 512-1800
Fax: (202) 512-2250

Level II codes/modifiers are also available on computer tape from the National Technical Information Services (NTIS). Their address is:

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22161

Sales Desk: (703) 487-4650, Subscriptions: (703) 487-4630, TDD (hearing impaired only): (703) 487-4639, RUSH Service (available for an additional fee): 1-800-553-NTIS, Fax: (703) 321-8547, and E-Mail: orders@ntis.fedworld.gov

442.1 Use and Maintenance of CPT-4 in HCPCS.--The text contains over seven thousand service codes, plus titles and modifiers. The AMA entered into an agreement with HCFA which states:

o The AMA permits HCFA, its agents, and other entities participating in programs administered by HCFA, and the health care field in general, to use CPT-4 codes and terminology in HCPCS;

o HCFA shall adopt and use CPT-4 in connection with HCPCS for reporting services under Medicare and Medicaid;

o HCFA agrees to include a statement in HCPCS that participants are authorized to use the copies of CPT-4 material in HCPCS only for purposes directly related to participating in HCFA programs and that permission for any other use must be obtained from the AMA;

o HCPCS shall be prepared in format(s) approved in writing by the AMA which include(s) appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA. You may publish, edit, and abridge CPT-4 terminology for Medicare use within your own hospital. You are not allowed to publish, edit, or abridge versions of CPT-4 for distribution outside of your hospital. This would violate copyright laws. You may print the codes and approved narrative descriptions for internal processing purposes in billing or in development requests relating to individual Medicare or Medicaid claims;

o Both AMA and HCFA will encourage health insurance organizations to adopt CPT-4 for the reporting of services to achieve the widest possible acceptance of the system and the uniformity of services reporting consistent therewith;

o The AMA recognizes that HCFA and other users of CPT-4 may not provide payment under their programs for certain procedures identified in CPT-4. Accordingly, HCFA and other health insurance organizations may independently establish policies and procedures governing the manner in which the codes are used within their operations; and

o The AMA Editorial Panel has the sole responsibility to revise, update, or modify CPT-4 codes.

The AMA updates and republishes CPT-4 annually and provides HCFA with the updated data. HCFA updates the alpha-numeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS file. The file is duplicated and distributed to Medicare contractors and State agencies. Your intermediary furnishes you with Level II of the codes as appropriate, or you may purchase them.

442.2 Addition, Deletion, and Change of Local Codes.--There may be procedures for which you bill, but are unable to assign a code. Contact your intermediary which will assign and coordinate the use of a local code. Furnish the intermediary with a full narrative description of the procedure, its projected volume, and the charge.

442.3 Use and Acceptance of HCPCS.--Use the CPT-4 portion of HCPCS for ambulatory surgical procedures and clinical diagnostic lab services. Use HCPCS codes for coding DME when you bill electronically.

HCPCS is updated annually to reflect changes in the practice of medicine and provision of health care. HCFA provides a file containing the updated HCPCS codes to contractors and Medicaid State agencies 90 days in advance of the implementation of the annual update.

442.5 HCPCS Training.--Your intermediary is responsible for training you in the use of HCPCS for Medicare billing. Bring any problems to its attention.

442.6 Reporting Hospital Outpatient Services Using HCFA Common Procedure Coding System (HCPCS).--

A. General.--Section 9343(g) of the Omnibus Budget Reconciliation Act (OBRA) of 1986 requires hospitals to report claims for outpatient services using HCPCS coding. HCPCS includes CPT-4 codes. In preparation of implementation of a hospital outpatient prospective payment system, hospitals are required to report all services except those identified below utilizing HCPCS coding in order to assure proper payment. This applies to acute care hospitals including those paid under alternative payment systems (e.g., Maryland), long-term care hospitals, rehabilitation hospitals, psychiatric hospitals, CAHs, hospital-based RHCs, and hospital based FQHCs. These instructions also apply to all-inclusive rate hospitals. If you have your intermediary's approval to combine bill the professional component charges, do not report HCPCS for the professional service revenue code, but report HCPCS for hospital services. Hospital-based ESRD facilities must also use HCPCS to bill for blood and blood products, and to bill for drugs and clinical diagnostic laboratory services paid outside the composite rate. In addition, you are required to report HCPCS and modifiers as described in §442.9, §433, and in PM-AB-98-63.

HCPCS codes are required for surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take home surgical dressings, therapies, preventative services, immunosuppressive drugs, drugs identified in §422, and the other services described in §442.7.

Claims that do not contain a HCPCS code for each service reported where HCPCS coding is required will be returned to you.

B. Line Item Dates of Service.--Report line item dates of service (FL 45 on the Form HCFA-1450) for every line where a HCPCS code is required on all outpatient bills, including bills where the from and thru dates are equal. Effective for services on or after April 1, 2000, your intermediary will return claims to provider (RTP), bills where a line item date of service is not entered for each HCPCS code reported.

Your intermediary will RTP claims if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period.

C. Reporting of Service Units.--The definition of service units (FL 46 on the Form HCFA-1450) is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the "number of times the service or procedure being reported was performed." You are required to make a numerical entry in FL 46.

EXAMPLES: If the following codes are performed once on a specific date of service, the entry in the "service units" field is as follows:

90849	Multiple-family group psychotherapy	units = 1
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report	units = 1
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests	units = no. of tests performed
95861	Needle electromyography two extremities with or without related paraspinal areas	units = 1

97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes, etc.	1 unit	8 minutes to < 23 minutes
		2 units	23 minutes to < 38 minutes
		3 units	38 minutes to < 53 minutes
		4 units	53 minutes to < 68 minutes
		5 units	68 minutes to < 83 minutes
		6 units	83 minutes to < 98 minutes
		7 units	98 minutes to < 113 minutes
		8 units	113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. You should not bill for services performed for < 8 minutes. The expectation (based on the work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If you have a practice of billing less than 15 minutes for a unit, these situations will be highlighted by your intermediary for review.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes time.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. (The total length of the treatment to the minute could be recorded instead.) If more than one CPT code is billed during a calender day, then the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of 97112 and 23 minutes of 97110 was furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took more time.

Your intermediary will RTP claims that do not contain service units for a given HCPCS code.

442.7 HCPCS Codes for Diagnostic Services and Medical Services.--The following instructions apply to reporting medical and additional diagnostic services other than radiology. They also include some diagnostic services subject to payment limitations. (See §443.) These reporting requirements apply to hospital services provided in clinics, emergency departments, and other outpatient departments. (See §437 for procedures for reporting laboratory services, §443 for reporting radiology, and §441 for reporting DME and prosthetics and orthotics.) In most cases, CPT-4 codes are used to code hospital services. However, for some categories of services, the use of CPT-4 codes would be so problematic that special HCPCS codes have been assigned. Use them in lieu of the CPT-4 codes.

CPT-4 codes are used by physicians to report physician services, and do not necessarily reflect the technical component of a service furnished by the hospital. Therefore, ignore any wording in the CPT-4 codes that indicates that the service must be performed by a physician. In cases where there are separate codes for the technical component, professional component, and/or complete procedure, use the code that represents the technical component. If there is no technical component code for the service, use the code that represents the complete procedure.

The following codes are required when the services you identify are provided. The codes are in the same order as they appear in CPT-4. Where CPT-4 codes are not appropriate, show the required HCPCS codes.

Visit - Do not report code 99201 if the sole reason for the visit was to undergo a laboratory, radiology, or diagnostic test, a surgical or medical procedure, or to receive psychiatric services, chemotherapy, physical therapy,occupational therapy, speech-language pathology, or cardiac

rehabilitation. Use code 99201 to report a visit in a hospital outpatient department (e.g., medical clinic, emergency department). A visit is defined as direct personal contact between a registered hospital outpatient and a physician (or other person who is authorized by State licensure law and where applicable, by hospital staff bylaws to order or provide services for the patient) for purposes of diagnosis or treatment of the patient.

Use code 99201 for new patients and code 99211 for established patients regardless of the duration or complexity of the visit. Report the number of visits in the units column. (Visits with more than one health professional, and multiple visits with the same health professional, that take place during the same session and at a single location within the hospital, constitute a single visit.) Code separately any additional services involving laboratory, radiology, diagnostic tests, or other procedures that are provided at the time of the visit. Report codes 99202 through 99215, 99281 through 99288, or 92002-92014 in lieu of 99201 if you wish, but this level of detail is not required.

Immunization Injections - codes 90700 - 90749 (Use the number of injections for units.)

Infusion Therapy (excludes chemotherapy) - Do not use CPT-4 codes 90780 or 90781 for infusion therapy. Instead, use the following alpha-numeric code:

Q0081 Infusion therapy, using other than chemotherapeutic drugs, per visit.

Therapeutic or Diagnostic Injections - You are not required to code these injections but, if you wish, code them using codes 90782 - 90799.

Psychiatry - codes 90801 - 90899. (Special instructions: Also use these codes to report drug and alcohol abuse services using the number of visits or services for units.)

Activity Therapy - Use the following alpha-numeric code for activity therapy furnished in connection with partial hospitalization. (Special instructions: Use the number of visits for units.)

Q0082 - Activity therapy furnished in connection with partial hospitalization, e.g., music, dance, art or play therapies that are not primarily recreational, per visit.

Biofeedback - codes 90901 and 90911. (Special instructions: Show the number of visits for units.)

Dialysis - Do not report HCPCS coding for dialysis.

Gastroenterology - codes 91000 - 91299 (Special instructions: Use the number of visits or services for units.)

Ambulance Services - Providers are required to report HCPCS and modifiers to describe the type of ambulance services, pickup-origins, and destinations.

Ophthalmology - codes 92018 - 92499 (Special instructions: Use the number of visits or services for units.)

Otorhinolaryngologic Services - codes 92502 - 92599 (Special instructions: Use the number of visits or services for units.)

Cardiovascular - codes 92950 - 93990 (Special instructions: Use only codes shown below. Use the number of services for units.)

Cardiovascular Therapeutic Services - codes 92950 - 92996

ECG - code 93005

Rhythm strip, telephonic - code 93012

Stress test - code 93017

Ergonovine provocation test - code 93024

Rhythm strip ECG - code 93041

Holter monitor - codes 93225, 93226, 93231, 93232, and 93236

Cardiography - codes G0005, G0006, G0015, 93012, 93270, and 93271

Various cardiovascular tests and services - codes Q0035 and 93278 - 93660

Plethysmography - code 93721

Miscellaneous cardiovascular tests - codes 93731 - 93740, 93770 and 93799

Cardiac rehabilitation - codes 93797 and 93798

Noninvasive vascular diagnostic studies - codes 93875 - 93990

Pulmonary - codes 94010 - 94070, and 94200 - 94799

Allergy Tests - codes 95004 - 95078. (Special instructions: Show the number of visits in the units column.)

Allergy Therapy - code 95115 (Special instructions: Use code 95115 to report all allergy therapies provided during a visit, without regard to the type or number of antigens or injections. Show the number of visits for units.) You may report codes 95115 - 95199, but this level of coding is not required.

Neurology - codes 95805 - 95999 (Special instructions: Show the number of visits or services for units.)

Central Nervous System Assessments/Tests - codes 96100 - 96117

Chemotherapy - Do not use CPT-4 codes for chemotherapy administration. Use the following alpha-numeric codes (Special instructions: Show the number of visits for units.):

Q0083 - Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit.

Q0084 - Chemotherapy administration by infusion technique only, per visit.

Q0085 - Chemotherapy administration by both infusion technique and other technique(s) (e.g., subcutaneous, intramuscular, push), per visit.

Code the drugs administered during chemotherapy using the following alpha-numeric HCPCS codes in the range of J8530 to J9999:

J8530	CYCLOPHOSPHAMIDE; ORAL, 25 MG
J5860	ETOPOSIDE; ORAL, 50 MG
J8600	MELPHALAN; ORAL, 2 MG
J8610	METHOTREXATE; ORAL, 2.5 MG
J8999	PRESCRIPTION DRUG, ORAL, CHEMOTHERAPEUTIC, NOS
J9000	DOXORUBICIN HCL, 10 MG
J9015	ALDESLEUKIN, PER SINGLE USE VIAL
J9020	ASPARAGINASE, 10,000 UNITS
J9031	BCG (INTRAVESICAL), PER INSTILLATION
J9040	BLEOMYCIN SULFATE, 15 UNITS
J9045	CARBOPLATIN, 50 MG
J9050	CARMUSTINE, 100 MG
J9060	CISPLATIN, POWDER OR SOLUTION, PER 10 MG
J9062	CISPLATIN, 50 MG
J9065	INJECTION, CLADRIBINE, PER 1 MG
J9070	CYCLOPHOSPHAMIDE, 100 MG
J9080	CYCLOPHOSPHAMIDE, 200 MG
J9090	CYCLOPHOSPHAMIDE, 500 MG
J9091	CYCLOPHOSPHAMIDE, 1.0 GRAM
J9092	CYCLOPHOSPHAMIDE, 2.0 GRAM
J9093	CYCLOPHOSPHAMIDE, LYOPHILIZED, 100 MG
J9094	CYCLOPHOSPHAMIDE, LYOPHILIZED, 200 MG
J9095	CYCLOPHOSPHAMIDE, LYOPHILIZED, 500 MG
J9096	CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM
J9097	CYCLOPHOSPHAMIDE, LYOPHILIZED, 2.0 GRAM
J9100	CYTARABINE, 100 MG
J9110	CYTARABINE, 500 MG
J9120	DACTINOMYCIN, 0.5 MG
J9130	DACARBAZINE, 100 MG
J9140	DACARBAZINE, 200 MG
J9150	DAUNORUBICIN, HYDROCHLORIDE, 10 MG
J9165	DIETHYLSTILBESTROL DIPHOSPHATE, PER 250 MG
J9181	ETOPOSIDE, 10 MG
J9182	ETOPOSIDE, 100 MG
J9185	FLUDARABINE PHOSPHATE, 50 MG
J9190	FLUOROURACIL, 500 MG
J9200	FLOXURIDINE, 500 MG
J9202	GOSERELIN ACETATE IMPLANT, PER 3.6 MG
J9208	IFOSFAMIDE, 1 GM
J9209	MESNA, 200 MG
J9211	IDARUBICIN HYDROCHLORIDE, 5 MG
J9213	INTERFERON, ALFA-2A, RECOMBINANT, 3 MILLION UNITS
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS
J9215	INTERFERON, ALFA-N3, (HUMAN LEUKOCYTE DERIVED), 250,000 IU
J9216	INTERFERON, GAMMA 1-B, 3 MILLION UNITS
J9217	LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG
J9218	LEUPROLIDE ACETATE, PER 1 MG
J9230	MECHLORETHAMINE HYDROCHLORIDE, (NITROGEN MUSTARD), 10 MG

J9245	INJECTION, MELPHALAN HYDROCHLORIDE, 50 MG
J9250	METHOTREXATE SODIUM, 5 MG
J9260	METHOTREXATE SODIUM, 50 MG
J9265	PACLITAXEL, 30 MG
J9266	PEGASPARGASE, PER SINGLE DOSE VIAL
J9268	PENTOSTATIN, PER 10 MG
J9270	PLICAMYCIN, 2.5 MG
J9280	MITOMYCIN, 5 MG
J9290	MITOMYCIN, 20 MG
J9291	MITOMYCIN, 40 MG
J9293	INJECTION, MITOXANTRONE HYDROCHLORIDE, PER 5 MG
J9320	STREPTOZOCIN, 1 GM
J9340	THIOTEPA, 15 MG
J9360	VINBLASTINE SULFATE, 1 MG
J9370	VINCRISTINE SULFATE, 1 MG
J9375	VINCRISTINE SULFATE, 2 MG
J9380	VINCRISTINE SULFATE, 5 MG
J9390	VINORELBINE TARTRATE, PER 10 MG
J9999	NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC DRUGS

Special Dermatological Procedures - codes 96900 - 96999 (Special instructions: Show the number of visits for units.)

Physical Medicine and Rehabilitation - codes 97001 - 97799.

Critical care - codes 99291 - 99292

Other Services - codes 99175 - 99186 and 99195.

452. BILLING FOR HOSPITAL OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

Medicare Part B coverage is available for hospital outpatient partial hospitalization services. (See §230.5.D.1 for a description of services covered under this benefit.)

A. Special Billing Requirements.--Sections 1861ff. of the Act defines the services covered under the partial hospitalization benefit in a hospital outpatient setting.

You are required to include a HCPCS/CPT code (if appropriate), a revenue code, and the charge for each individual covered service furnished under a partial hospitalization program. This assures that only those partial hospitalization services covered under §1861ff. of the Act are paid by the Medicare program.

Bill for partial hospitalization services on the HCFA-1450 under bill type 13X or 14X, as appropriate. Follow billing procedures in §460 with the following exceptions:

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
250	Drugs and Biologicals
43X	Occupational Therapy
904	Activity Therapy
910	Psychiatric/Psychological Services
914	Individual Therapy
915	Group Therapy
916	Family Therapy
918	Testing
942	Education Training

You are required to report condition code 41 in FLs 24-30 of Form HCFA-1450 to indicate the claim is for partial hospitalization services.

You are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
43X	Occupational Therapy (Partial Hospitalization)	*G0129
904	Activity Therapy (Partial Hospitalization)	**Q0082
910	Psychiatric General Services	90801, 90802, 90875, 90876, 90899, or 97770
914	Individual Psychotherapy	90816, 90818, 90821, 90823, 90826, or 90828
915	Group Therapy	90849, 90853, or 90857
916	Family Psychotherapy	90846, 90847, or 90849
918	Psychiatric Testing	96100, 96115, or 96117
942	Education Training	***G0172

Your intermediary will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes.

*The definition of code G0129 is as follows:

"Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization program, per day."

**The definition of code Q0082 has been changed. The new definition is as follows:

"Activity therapy furnished as a component of a partial hospitalization treatment program (e.g., music, dance, art or play therapies that are not primarily recreational), per day."

***The definition of code G0172 is as follows:

"Training and educational services furnished as a component of a partial hospitalization treatment program, per day."

Revenue code 250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

The professional services listed below when provided in a hospital outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants, (PAs)), bill the Medicare Part B carrier directly for the professional services furnished to your partial hospitalization patients. You can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The following direct professional services are unbundled and paid as partial hospitalization services.

- o Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- o PA services, as defined in §1861(s)(2)(K)(i) of the Act;

- o Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and

- o Clinical psychologist services, as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to hospital patients, including partial hospitalization patients. You must bill your intermediary for such nonphysician practitioner services as partial hospitalization services. Payment is made to you for these services.

PA services can be billed only by the actual employer of the PA. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in your hospital, the physician and not you is responsible for billing the carrier on the HCFA-1500 for the services of the PA.

B. Outpatient Mental Health Treatment Limitation.--The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to your intermediary as partial hospitalization services.

C. Reporting of Service Units.--Visits should no longer be reported as units. Instead, you are required to report in FL 46, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for the following partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100 which is defined in one hour intervals) for a total of 3 hours during one day. The provider reports revenue code 918 in FL 42, HCPCS code 96100 in FL 44, and "three" units in FL 46.

When reporting service units for HCPCS codes where the definition of the procedure does not include any time frame (either minutes, hours or days), do not bill for sessions of less than 45 minutes.

Your intermediary will RTP claims that contain more than one unit for HCPCS codes G0129, Q0082, and G0172, or that do not contain service units for a given HCPCS code.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

D. Line Item Date of Service Reporting.--You are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	915	90849	19980505	1	$ 80.00
61	915	90849	19980529	2	$160.00

For the hard copy UB-92 (HCFA Form-1450), report as follows:

FL 42	FL44	FL45	FL46	FL47
915	90849	05-05-98	1	$ 80.00
915	90849	05-29-98	2	$160.00

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report as follows:

LX*1~
SV2*915*HC:90849*80*UN*1~
DTP*472*D8*19990505~
LX*2~
SV2*915*HC:90849*160*UN*2~
DTP*472*D8*19990529~

Your intermediary will RTP claims if a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported fall outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after April 1, 2000.

E. Payment.--Your intermediary makes payment to you on a reasonable cost basis until July 1, 2000 for partial hospitalization services. The Part B deductible and coinsurance apply.

During the year, your intermediary will make payment at an interim rate based on a percentage of your billed charges. At the end of the year, you will be paid the reasonable costs incurred in furnishing partial hospitalization services, based upon the Medicare cost report you file with your intermediary. Information applicable to determining interim rates for partial hospitalization services furnished as hospital outpatient services are contained in §2400ff. of the Provider Reimbursement Manual. Beginning with services provided on or after July 1, 2000, payment will be made under the hospital outpatient prospective payment system for partial hospitalization services. You must continue to maintain documentation to support medical necessity of each service provided, including beginning and ending time.

453. BILLING FOR HOSPITAL OUTPATIENT SERVICES FURNISHED BY CLINICAL SOCIAL WORKERS (CSWs)

Payment may be made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting.

A. Fee Schedule to be Used for Payment of CSW Services.--The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists

B. Payment Limitation.--CSW services are subject to the outpatient mental health services limitation in §1833(c) of the Act. Carriers apply the limitation of 62.5 percent to the lesser of the actual charge or fee schedule amount. Diagnostic services are not subject to the limitation.

C. Coinsurance and Deductible.--The annual Part B deductible and the 20 percent coinsurance apply to CSW services.

D. Billing.--

1. Hospital Outpatient Services--CSWs do not bill directly for these services. Hospital outpatient services are bundled and you bill the carrier for the services on Form HCFA-1500. These services are not billed to your intermediary.

2. Partial Hospitalization Services--CSW services furnished under the partial hospitalization program are also bundled. However, bill your intermediary for these services. Payment is made on a reasonable cost basis.

(See §452 for an explanation.)

454. MAMMOGRAPHY QUALITY STANDARDS ACT (MQSA)

A. Background.--The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the FDA to continue to operate. On September 30, 1994, HCFA stopped conducting surveys of screening mammography facilities. The responsibility for collecting certificate fees and surveying mammography facilities (screening and diagnostic) was transferred to the FDA, Center for Devices and Radiological Health.

B. General.--Your intermediary will pay diagnostic and screening mammography services for claims submitted by you only if you have been issued an MQSA certificate by FDA. Your intermediary is responsible for determining that you have a certificate prior to payment. In addition, it is responsible for ensuring that payment is not made in situations where your certificate has expired, or it has been suspended or revoked or you have been issued a written notification by the FDA stating that you must cease conducting mammography examinations because you are not in compliance with certain critical FDA certification requirements.

C. Under Arrangements.--When you obtain mammography services for your patients under arrangements with another facility, you must ensure that the facility performing the services has been issued a MQSA certificate from the FDA.

D. Denied Services.--When your intermediary determines the facility that performed the mammography service has not been issued a certificate by FDA, or the certificate is suspended or revoked, your claim will be denied utilizing the denial language in §451.G, related to certified facilities.

455. OUTPATIENT OBSERVATION SERVICES

A. Observation Services.--Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient. Such services are covered only when provided by order of a physician or another individual authorized by State licensure law and hospital bylaws to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed one day. Some patients, however, may require a second day of outpatient observation services. Services exceeding 48 hours will be denied. (See §230.6.)

If you believe that exceptional circumstances in a particular case justify approval of additional time in outpatient observation status, you may request an exception to the denial of services from your intermediary. See §230.6D for procedures for requesting an exception.

Bill for outpatient observation services using the following revenue code.

Revenue Code	Description
762	Observation Services

For observation services, report the number of hours in the units field. Begin counting when the patient is placed in the observation bed, and round to the nearest hour. If necessary, verify the time in the nurses' notes. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurse's notes and discharged to home at 9:45 p.m. should have a "7" placed in the units field.

B. Services Not Covered as Observation Services.--See §230.6E for non-covered services.

If you have provided hours of observation for non-covered services, and have given proper notice to the beneficiary, show only covered observation services. If you have provided more than 48 hours of observation, but think that the additional hours qualify for coverage, show all hours of service you provided in the units field. The intermediary will suspend the claim for documentation of the medical necessity of all observation services. If any such services are denied, the beneficiary cannot be held liable for payment.

460. COMPLETION OF FORM HCFA-1450 FOR INPATIENT AND/OR OUTPATIENT BILLING

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on Form HCFA-1450 are described, but detailed information is given only for items required for Medicare claims.

This section details only the data elements which are required for Medicare billing. When billing multiple third parties, complete all items required by each payer who is to receive a copy.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

Effective April 1, 2000, HCFA will extend the claim size to 450 lines. For the hard copy UB-92 or HCFA-1450, this simply means that your intermediary will accept claims of up to 9 pages. For the electronic format, the new requirements are described in Addendum A.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is your name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.

FL 2. (Untitled)
Not Required. This is one of four State use fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is a "frequency" code.

Code Structure (Only codes used to bill Medicare are shown.)

1st Digit-Type of Facility
1 - Hospital
4 - Religious Non-Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit-Bill Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).

4 - Other - Part B - (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to "nonpatients," and referenced diagnostic services).
7 - Subacute Inpatient (Revenue Code 19X required)
8 - Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9 - Reserved for National Assignment

2nd Digit-Classification (Clinics Only)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free Standing
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center
7-8 Reserved for National Assignment
9 - OTHER

2nd Digit-Classification (Special Facilities Only)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center Services to Hospital Outpatients
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6-8 Reserved for National Assignment
9 - OTHER

3rd Digit-Frequency	Definition
A - Hospice Admission Notice	Use when the hospice is submitting Form HCFA-1450 as an Admission Notice.
B - Hospice Termination/ Revocation Notice	Use when the hospice is submitting Form HCFA-1450 as a notice of termination/revocation for a previously posted hospice election.
C - Hospice Change of Provider Notice	Use when Form HCFA-1450 is used as a Notice of Change to the hospice provider.
D - Hospice Election Void/ Cancel	Use when Form HCFA-1450 is used as a Notice of a Void/Cancel of hospice election.
E - Hospice Change of Ownership	Use when Form HCFA-1450 is used as a Notice of Change in Ownership for the hospice.
F - Beneficiary Initiated Adjustment Claim	Used to identify adjustments initiated by the beneficiary. For intermediary use only.
G - CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For intermediary use only.
H - HCFA Initiated Adjustment Claim	Used to identify adjustments initiated by HCFA. For intermediary use only.
I - Intermediary Adjustment Claim (Other Than Pro or Provider)	Used to identify adjustments initiated by the intermediary. For intermediary use only.

J - Initiated Adjustment Claim-Other	Used to identify adjustments initiated by other entities. For intermediary use only.
K - OIG Initiated Adjustment Claim	Used to identify adjustments initiated by OIG. For intermediary use only.
M - MSP Initiated Adjustment Claim	Used to identify adjustments initiated by MSP. For intermediary use only. Note: MSP takes precedence over other adjustment sources.
P - PRO Adjustment Claim	Used to identify an adjustment initiated as a result of a PRO review. For intermediary use only.
0 - Nonpayment/Zero Claims	Use this code when you do not anticipate payment from the payer for the bill, but is informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to you.
1 - Admit Through Discharge Claim	Use this code for bill encompassing an entire inpatient confinement or course of outpatient treatment for which you expect payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2 - Interim-First Claim	Use this code for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment.
3 - Interim-Continuing Claims (Not valid for PPS Bills)	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4 - Interim-Last Claim (Not valid for PPS Bills)	Use this code for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (FL 6) is the discharge for this treatment.
5 - Late Charge Only	Use for outpatient claims only. Late charges are not accepted for Medicare inpatient or ASC claims.
7 - Replacement of Prior Claim	Use to correct a previously submitted bill. Apply this code to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted.A code “7" (Replacement of Prior Claim) is being submitted showing corrected information.

FL 5. Federal Tax Number
Not Required.

FL 6. Statement Covers Period (From-Through)
Required. Enter the beginning and ending dates of the period included on this bill in numeric fields (MM-DD-YY). Days before the patient's entitlement are not shown. Use the "From" date to determine timely filing.

FL 7. Covered Days
Required. Enter the total number of covered days during the billing period applicable to the cost report, including lifetime reserve days elected for which you requested Medicare payment. This should be the total of accommodation units reported in FL 46. Exclude any days classified as noncovered as defined in FL 8, leave of absence days, and the day of discharge or death.

Do not deduct any days for payment made under Workers' Compensation (WC), automobile medical, no-fault, liability insurance, an EGHP for an ESRD beneficiary, employed beneficiaries and spouses age 65 or over or a LGHP for disabled beneficiaries. Your intermediary calculates utilization based upon the amount Medicare will pay and makes the necessary utilization adjustment. (See §§469B and C, and 470B and C, 471B and C, 472B and C, and 475.)

See §411.1C "Utilization Chargeable" for the special situations requiring that no program payment bills show an entry of covered days in FL 7.

See §415.1 if you are being paid under PPS.

FL 8. Noncovered Days
Required. Enter the total number of noncovered days during the billing period within the "From" and "Through" date (FL 6) that are not claimable as Medicare patient days on the cost report and for which the beneficiary will not be charged utilization for Part A services. Noncovered days include:

- Days for which no Part A payment can be made because the services rendered were furnished without cost or will be paid for by the VA. (See §260.3D1.)
- Days for which no Part A payment can be made because payment will be made under a National Institutes of Health grant;
- Days after the date covered services ended, such as noncovered level of care, or emergency services after the emergency has ended in nonparticipating institutions;
- Days for which no Part A payment can be made because the patient was on a leave of absence and was not in the hospital. (See §216ff.);
- Days for which no Part A payment can be made because a hospital whose provider agreement has terminated, expired, or been canceled may only be paid for covered inpatient services during the limited period following such termination, expiration, or cancellation. All days after the expiration of the period are noncovered. See §400.11A for determining the effective date of the limited period and §400.11B for billing for Part B services; and

98X Professional Fees (Cont.)

Subcategory	Standard Abbreviations
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X Patient Convenience Items

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 -Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 Other Patient Convenience Items	PT CONVENCE/OTH

FL 43. Revenue Description
Not Required. Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also see FL 84, Remarks.)

FL 44. HCPCS/Rates
Required. When coding HCPCS for outpatient services, (i.e., outpatient surgery bills, clinical diagnostic laboratory bills for outpatients or nonpatients, radiology, other diagnostic services, orthotic/prosthetic devices, take home surgical dressings, therapies (identified in AB-98-63), preventative services, drugs identified in §443.C.3, and other services described in §442.7 and §442.8), enter the HCPCS code describing the procedure in the space to the right of the dotted line.

On inpatient hospital bills the accommodation rate is shown here.

FL 45. Service Date
Required. You are required to report line item dates of service for every line where a HCPCS code is reported on all outpatient bills.

FL 46. Units of Service
Required. Enter the number of digits or units of service on the line adjacent to revenue code and description where appropriate, e.g., number of covered days in a particular type of accommodation, pints of blood. When HCPCS codes are required for hospital outpatient services, the units are equal to the number of times the procedure/service being reported was performed. (See §442.6.) Provide the number of covered days, visits, treatments, tests, etc., as applicable for the following:

Accommodation days - 100s, 150s, 200s, 210s (days)
Blood pints - 380s (pints)
DME - 290s (rental months)
Emergency room - 450, 452, and 459 (HCPCS code definition for visit or procedure)
Clinic - 510s and 520s (HCPCS code definition for visit or procedure)
Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (Units are equal to the number of times the procedure/service being reported was performed.)
Outpatient clinical diagnostic laboratory tests - 30X-31X (tests)
Radiology - 32x, 34x, 35x, 40x, 61x, and 333 (HCPCS code definition of tests or services)
Oxygen - 600s (rental months, feet, or pounds)
Hemophilia blood clotting factors - 636

Enter up to seven numeric digits. Show charges for noncovered services as noncovered.

FL 47. Total Charges
Required. Sum the total charges for the billing period by revenue code (FL 42) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 "0001" which represents the grand total of all charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

HCFA policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement (PS&R) reports that you derive from the bill.